Outstanding Medical Bills—

Christina,

I've got several bills on which I am currently making payments and some bills that require payment.

I've itemized the bills in addition to including them for your perusal:

COLLECTOR	ACCOUNT NUMBER	BALANCE
1. The Bortolazzo Group LLC-KENN	K2-176284.0	73.38
2. Marietta Diagnostic Center LLC	310*23248.1	28.00
3. Children's Healthcare of Atlanta	600043298	110.00
4. Wellstar Kennestone Hospital	K1005502445	569.72
5. The Bortolazzo Group LLC PAUL	2-45619.0	22.31
6. Wellstar Paulding Hospital	L0929100719	45.00
		Total Outstanding Balance $848.41

I also have some medical expenses that I have already paid. I don't know if these would be included or not, but here they are.

COLLECTOR	ACCOUNT NUMBER	AMT. PAID
1. Publix Pharmacy	N/A	$94.04
2. Sherwood Clinical	N/A	$54.32
3. Atlanta Brain & Spine	11756	$28.82
4. Piedmont Urology	10421	$46.00
		Total Paid Out of Pocket $223.18

Piedmont Urology, PC
95 Collier Rd NW
Suite 6025
Atlanta, GA 30309-1752

IF PAYING BY VISA, MASTERCARD OR DISCOVER, FILL OUT BELOW

☐ VISA ☐ MASTERCARD ☐ DISCOVER

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

Page: 1 of 1

For all billing questions, please call: 404-355-6265
Office Hours: 8:30 am to 4:30 pm

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
02/18/2010	$46.00	10421

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

ADDRESSEE:

12416 - 184

ADAM RUSSELL
2707 COUNTY LINE RD NW
ACWORTH GA 30101-6921

MAKE CHECKS PAYABLE / REMIT TO:

Piedmont Urology, PC
95 Collier Rd NW
Suite 6025
Atlanta, GA 30309-1752

PAID

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

Date	Description / Procedure	Insurance Charges/ Adjust	Patient Charges/ Credits
	Adam Russell(10421)/William F Allen III MD/028495		
	Location: Piedmont Urology PC		
04/09/2009	99241 Office consultation	$25.00	$75.00
04/09/2009	55250 Vasectomy, bilateral including postoperative semen exa	$830.00	$.00
04/10/2009	Payment from Russell, Adam	$.00	$-75.00
04/22/2009	Disallowed Adjustment from United Healthcare	$-138.02	$.00
04/22/2009	Payment from United Healthcare	$-281.26	$.00
04/22/2009	Transfer from Insurance	$-435.72	$435.72
	This amount has been applied to your deductible and is your responsibility. Please remit your payment. Thank you.		
05/11/2009	Payment from Russell, Adam	$.00	$-147.24
05/30/2009	Payment from Russell, Adam	$.00	$-144.48
07/27/2009	Payment from Russell, Adam	$.00	$-20.00
09/08/2009	Payment from Russell, Adam	$.00	$-24.00
10/07/2009	Payment from Russell, Adam	$.00	$-34.00
12/24/2009	Payment from Russell, Adam	$.00	$-20.00
	Balance:	$.00	$46.00

ADAM L RUSSELL
2707 COUNTY LINE RD NW
ACWORTH, GA 30101

1086

2/25/10 Date

64-5/610 GA 678

Pay to the Order of PIEDMONT UROLOGY $ 46.00

FORTY SIX & 00/100 Dollars

Security Features Details on Back.

Bank of America

ACH R/T 061000052

For 10421

⑆061000052⑆ 334015477201⑈1086

TOTAL BALANCE	INSURANCE BALANCE	PATIENT BALANCE
$46.00	$.00	$46.00

Please Pay This Amount

Reflects transactions posted through 02/18/2010 for account # 10421

Piedmont Urology, PC
95 Collier Rd NW
Suite 6025
Atlanta, GA 30309-1752

1 of 1

STATEMENT

SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

12416 - 184

185779 185779 000240L

Atlanta Brain and Spine Care
P O Box 932866

Atlanta, GA 31193
ADDRESS SERVICE REQUESTED

IF PAYING BY CREDIT CARD, FILL OUT BELOW (3 or 4 digit number on the back of your credit card).
CHECK CARD USING FOR PAYMENT
☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	VIN #	AMOUNT
SIGNATURE		EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
01/25/2010	$28.82	11756

PHONE NUMBER: 404-350-0106

PAGE 1

SHOW AMOUNT PAID HERE $

ADDRESSEE:

Adam Russell
2707 County Line Road

Acworth, GA 30101

REMIT TO:

Atlanta Brain and Spine Care
P O Box 932866

Atlanta, GA 31193

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

Statement may reflect multiple patient accounts

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	CPT	DESCRIPTION	CHARGES	UNITS	TRANSACTION FEE TOTAL	INSURANCE AMOUNT	PATIENT AMOUNT
Adam Russell(12884)/Vishal Gala MD/044439							
	722.52	Degeneration of lumbar or lumbosacral intervertebral disc	$.00	.00	$.00	$.00	
12/16/2009	99244	Office Consultation, Comprehensive	$525.00	1.00	$525.00	$525.00	$.00
12/31/2009		Contractual Allowance Adjustment from UHC	$-236.74	.00	$-236.74	$-236.74	$.00
12/31/2009		Payment from UHC	$-259.44	.00	$-259.44	$-259.44	$.00
12/31/2009		Transfer from Insurance	$-28.82	.00	$-28.82	$-28.82	$28.82
					Balance:	$.00	$28.82

PAID

ADAM L RUSSELL
2707 COUNTY LINE RD NW
ACWORTH, GA 30101

1087

64-5/610 GA
678

Date 2-25-10

Pay to the Order of Atlanta Brain & Spin $ 28.82

TWENTY EIGHT & 82/100 Dollars

Security Features Details on Back.

Bank of America

ACH R/T 061000052

For 11756

MP

⑆061000052⑆ 334015477201⑈1087

SHERWOOD CLINICAL -MAIN
415 FISK AVENUE
DEMOREST, GA 30535
800-847-3987
Provider #
Tax ID # 582213506

Invoice # 105555

INVOICE

Date 02/17/2010

To RUSSELL, ANNA BELLA
2707 County Line Road
Acworth, Ga. 30101

Re RUSSELL, ANNA BELLA
2707 County LIne Road
ACWORTH, GA 30101
404-642-4331

Insured RUSSELL, ANNA BELLA
1864 CANOE RIDGE
KENNESAW, GA 30152
404-642-4331

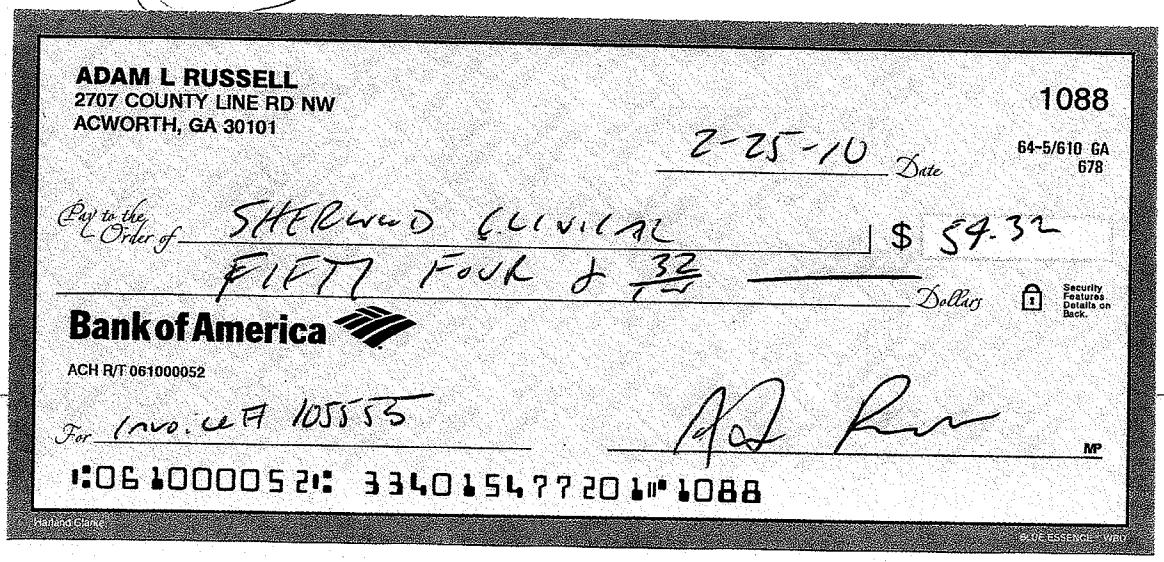
Policy #
Group #

Description NEBULIZER

Service Dates **From** 09/08/2009 **To** 09/08/2009 **Days** 1

PAID

Qty	Delivered	Description	Unit Price	Total Price
1	09/08/2009	UHC COINSURANCE	$54.32	$54.32


ADAM L RUSSELL
2707 COUNTY LINE RD NW
ACWORTH, GA 30101

1088

64-5/610 GA
678

2-25-10 Date

Pay to the Order of SHERWOOD CLINICAL $ 54.32

FIFTY FOUR & 32/100 Dollars

Security Features Details on Back.

Bank of America

ACH R/T 061000052

For Invo. # 105555

MP

⑆061000052⑆ 3340154772 0⑈1088

Total Price	**$54.32**
Amount Paid	**$0.00**
Amount Adjusted	**$0.00**
Balance Due	**$54.32**

Terms PAYABLE ON RECEIPT.

Make Check Payable to SHERWOOD CLINICAL
415 FISK AVE
DEMOREST GA 30535

Phone 706-776-9127

COINSURANCE

RUSSELL, ANNABELLA

2707 COUNTY LINE RD ACWORTH, GA 30101
(404) 642-4331 DOB: 05/07/2007

P U B L I X

P H A R M A C Y

Feeling well. Living better.

#0566 ● 1727 MARS HILL ROAD ● ACWORTH, GA 30101
NCPDP# 1142746 ● (770) 218-2426 ● Dispensed by: GMK

Your Prescription

AMOUNT DUE: $44.09

Ins. PAI
REF.# FKWK1P1

Your plan has saved you $277.86

Rx **6819434** **Refill**
Filled: 04/28/2010
BUDESONIDE 0.25MG/2 SUS
NDC: 00093-6815-73 Mfg: TEVA PHA
Qty. 120.0 Days: 30
May be refilled until 12/15/2010
Dr. COLON, ENID

Your Safety Check

NDC # 00093-6815-73
Side 1
Side 2
Form
Shape
Color

Your Allergies

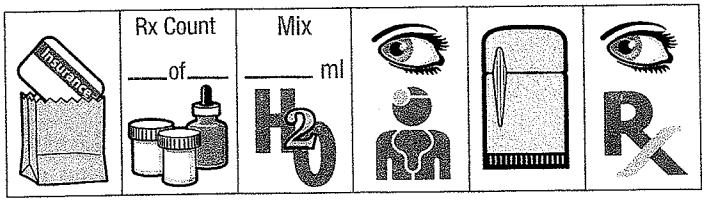
1. NO KNOWN DRUG ALLERG

Your Medication

1-Rinse mouth aft dose to reduce dryness/hoarseness
2-Do not exceed recommended dosage
3-Follow dosing directions very carefully.
4-Shake gently
5-Check with Dr. before taking any other medicine
6-Promptly report unusual symptoms/effects to Dr
7-If condition persists or worsens notify Dr
8-Inform Dr/Dentist prior to any type of surgery.

Your Messages

- ASK YOUR PHARMACIST ABOUT AUTO-REFILLS.
- WE FILL WORKERS' COMPENSATION AND CALL YOUR DOCTOR FOR MEDICAL ADVICE
- ABOUT SIDE EFFECTS. YOU MAY REPORT SIDE EFFECTS TO THE FDA
- AT 1-800-FDA-1088.



RUSSELL, ADAM L

2707 COUNTY LINE RD ACWORTH, GA 30101
(404) 642-4331 DOB: 01/30/1976

P U B L I X

P H A R M A C Y

Feeling well. Living better.

#0566 ● 1727 MARS HILL ROAD ● ACWORTH, GA 30101
NCPDP# 1142746 ● (770) 218-2426 ● Dispensed by: TM5

Your Prescription

AMOUNT DUE: $49.95

Rx **6814811** **Refill**
Filled: 05/10/2010
CIALIS 5MG **TAB L**
NDC: 00002-4462-30 Mfg: LILLY
Qty. 10.00 Days: 10
1 REFILL BY 09/30/2010
Dr. LONG, KATHRYN

Your Safety Check

NDC # 00002-4462-30
Side 1 C 5
Side 2
Form TABLET
Shape ALMOND
Color YELLOW

Your Allergies

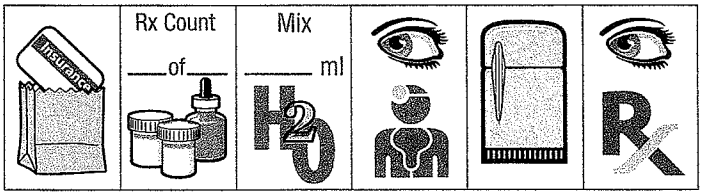
1. NO KNOWN DRUG ALLERG

Your Medication

1-Do not exceed recommended dosage
2-Consult patient-package information
3-Check w/Dr about drinking grapefruit juice.
4-Do not use w/isosorbide, nitroglycerin, nitrates.
5-Check with Dr. before taking any other medicine
6-May cause headache. Consult Dr if severe.
7-Promptly report unusual symptoms/effects to Dr
8-Tell doctor your complete medical history

Your Messages

- ASK YOUR PHARMACIST ABOUT AUTO-REFILLS.
- WE FILL WORKERS' COMPENSATION AND CALL YOUR DOCTOR FOR MEDICAL ADVICE
- ABOUT SIDE EFFECTS. YOU MAY REPORT SIDE EFFECTS TO THE FDA
- AT 1-800-FDA-1088.



The Bortolazzo Group LLC-KENN
P.O. Box 5518
Athens, GA 30604
Return Service Requested

If you have any questions regarding your bill, please contact our office at 706-310-0381 or 1-800-532-6151 between 8:30 am - 5:00 pm Mon-Fri.

IF PAYING BY VISA OR MASTERCARD, FILL OUT BELOW

☐ VISA ☐ MASTERCARD

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
04/02/10	$83.38	K2-176284.0

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

ADDRESSEE:

10211-445

K2-176284.0
ADAM RUSSELL
2707 COUNTY LINE RD NW
ACWORTH GA 30101-6921

MAKE CHECKS PAYABLE / REMIT TO:

K2-176284.0
THE BORTOLAZZO GROUP LLC KENN
P.O. BOX 277234
ATLANTA, GA 30384

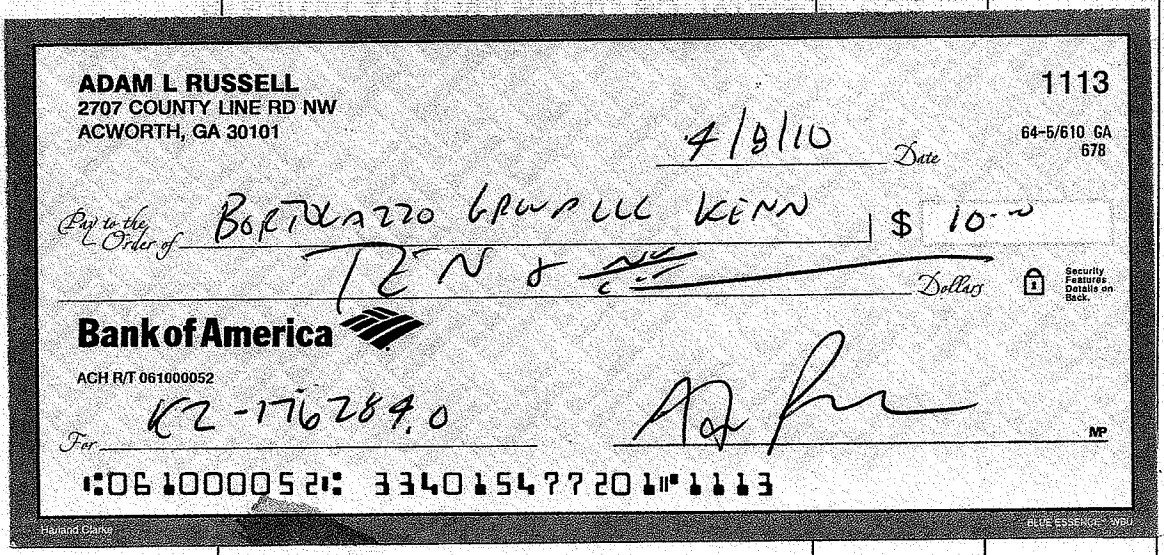
☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

PROVIDERS: MARK A BROWN

DATE	NAME	DESCRIPTION	CHARGES	PMT/ADJ	BALANCE
02/24/10	ANNABELLA	ED E&M LEVEL 5	654.00		
03/20/10	ANNABELLA	PAY UHC/ F.H. 03-22-10		-472.52	
03/20/10	ANNABELLA	WO UCR		-98.10	
03/20/10	ANNABELLA	CO-INSURANCE $83.38	0.00		
		PATIENT RESPONSIBILITY--->			83.38



****
PLEASE FORWARD ALL CORRESPONDENCE AND PAYMENTS TO:
The Bortolazzo Group LLC-KENN
P.O. BOX 277234
ATLANTA, GA 30384
****

Balances	Current	31-60	61-90	Over 90	Balance
Patient	83.38	0.00	0.00	0.00	83.38
Insurance	0.00	0.00	0.00	0.00	0.00
Total	83.38	0.00	0.00	0.00	83.38

$ 83.38

Please Pay Above Amount

This is your Emergency Room Physician's Bill and payment in full is due upon receipt. This balance is YOUR RESPONSIBILITY. Please note change of address on the back of this statement. If we do not have your insurance information please attach a copy of the front and back of your insurance card. Thank you for choosing Wellstar Kennestone Hospital.

Patient Last Payment Date:
Patient Last Payment Amt: $0.00
Statement Date: 04/02/10

STATEMENT
SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

10211-445

MARIETTA DIAGNOSTIC CENTER LLC
PO BOX 465448
LAWRENCEVILLE GA 30 30042

Date: 02/04/2010

Amount Due: $56.50

Temp - Return Service Requested

$56.50

JCBC*310*23248.1

MED541.A3A7WJ000009.J04E17.000747 000747

ADAM L RUSSELL
2707 COUNTY LINE RD NW
ACWORTH GA 30101-6921

Mail Payment to:

MARIETTA DIAGNOSTIC CENTER LLC
PO BOX 465448
LAWRENCEVILLE GA 30042-5448

MED541

Patient Name - ADAM RUSSELL
Account Number - 310*23248.1
Account Balance - $56.50

Place of Service: MARIETTA DIAG CENTER
KATHRYN LONG MD
Date of Service: 12/03/2009

Dear ADAM RUSSELL:

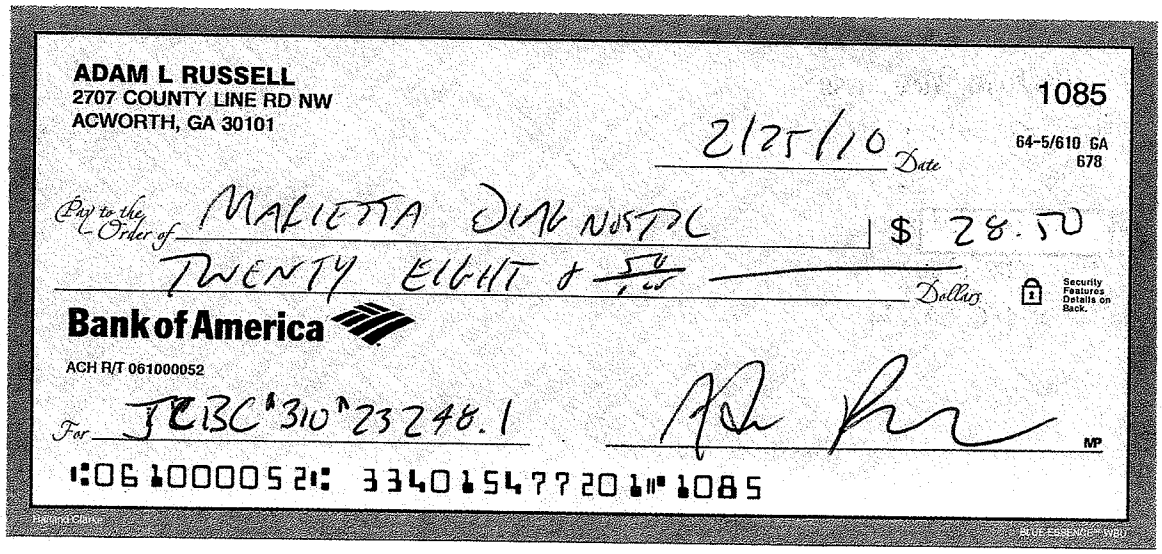
This is a reminder that payment on your account is now due.

Please mail payment in full today to the address shown above. To insure proper credit, enclose this letter with payment and write your account number on the check.

If you have any questions, please call the number listed below. Thank you for your prompt attention.

If you have already mailed payment in full, please disregard this request.

Sincerely,
BUSINESS OFFICE
800/795-5777



For questions call, 770/237-1259 and when prompted enter your identification number as follows 4625*23248*1

Children's Healthcare of Atlanta

PO Box 3475
Toledo, OH 43607-0475

0101

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.
CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
01/23/2010	125.00	600043298

Page: 1 of 1

SHOW AMOUNT PAID HERE $

500333

1670 01
ADAM RUSSELL
2707 COUNTY LINE RD NW
ACWORTH, GA 30101-6921

Childrens Healthcare of Atlanta
PO BOX 116210
ATLANTA, GA 30368-6210

Patient Name: Russell, Annabella Account Number: 600043298 Date of Service: 05/31/2009

Dear Adam Russell,

This account is for professional services of a physician.

Your account is now seriously past due and demands your immediate attention.

We have attempted to contact you by phone or previous correspondence in an effort to work with you to resolve this debt.

We are now at the point of exhausting our internal resources on your past due balance and must hear from you immediately to avoid any further collection activity.

We are available to help you with payment by phone in the form of a check or credit card at no additional charge. Our collection team is available by phone (404) 785-5589 or toll-free (866) 415-7358 between the hours of 8:30 am to 4:00pm Monday - Friday.

Please help us keep your account in good standing. Please detach the tear off portion of this letter and remit with your payment today.

Sincerely,

Collection Manager

WELLSTAR®

WELLSTAR KENNESTONE HOSPITAL C
PO BOX 406161
ATLANTA GA 30384

FC = 52

KEN11O.A3DR6I001049.J050TA.002057 001029

ADAM LEE RUSSELL
2707 COUNTY LINE RD NW
ACWORTH GA 30101-6921

Account Summary

Patient Name	ANNABELLA RUSSELL
Account Number	K1005502445
Bill Date	05/04/2010
Type of Service	Outpatient Kids Center
Service Dates	02/24/2010 - 02/25/2010
Total Charges	$3,089.75
Patient Payments	-$317.14
Insurance Payments/Adjustments	-$2,202.89
Amount Now Due	**$569.72**

Insurance Information / Policy Number

Insurance 1 - UHC /SHBP CHOICE OR CHOICE	XXXXX3987
Insurance 2 - PROFEE UHC /SHBP CHOICE PLUS	XXXXX3987

If your insurance information is incorrect or if you have insurance that is not listed, please contact WellStar Customer Service at 678-838-5750 as soon as possible. Changes to this information may affect how your insurance company pays your claim and may affect the amount due from you.

Important Message

Thank you for utilizing the WellStar Health System as your healthcare provider. It is our mission to create and deliver high quality hospital, physician and other healthcare related services that improve the health and well-being of the individuals and communities we serve.

Payment on this account is **now past due**. Wellstar depends on prompt payment of all accounts in order to provide care to the community we serve. Please remit payment as soon as possible in order to settle your account, and further, to help us provide needed care to your family and others in the community.

Failure to pay your account can result in future assignment to collection agencies or attorneys for further action. You may still contact **Customer Service** at the numbers below should you need assistance with questions or payment arrangement options.

A summary of your charges and information about paying your bill is found on the reverse side of this statement. If you need a detailed list of your charges, please call WellStar Customer Service at 678-838-5750.

Contact Us

Billing related questions?
Contact Customer Service at 678-838-5750
Office Hours are 8:00 am - 4:30 pm, Monday - Friday

Online Billing Manager, 24 hours per day, 7 days per week. www.wellstar.org. A simple and easy way to access your updated account information and pay your accounts online.

WEL11

WEL11

WELLSTAR®

- ✓ Make Check Payable to WellStar Health System.
- ✓ Please include your Phone No. on your check.
- ✓ Enclose this payment stub with your payment

Amount Paid
$

GUARANTOR NAME	ACCOUNT NUMBER	AMOUNT DUE	METHOD OF PAYMENT
ADAM LEE RUSSELL	K1005502445	$569.72	Check One ☐ Payment Enclosed ☐ Charge (Complete below)

Complete the reverse side of this form only if your address has changed.

WELLSTAR KENNESTONE HOSPITAL
PO BOX 406161
ATLANTA GA 30384-6161

☐ VISA ☐ MasterCard ☐ ☐ DISCOVER

Credit Card Number

Credit Card Expiration Date — 3 Digit Security Code (on back)

Credit Card Holder's Signature — (Cannot be processed without Signature)

THE BORTOLAZZO GROUP LLC PAUL
P.O. BOX 277234
ATLANTA, GA 30384-7234

If Paying by Credit Card, Fill Out Below

MASTERCARD ☐ VISA ☐ OTHER ☐

Card Number | Sec. Code | Exp. Date

Signature

Last Payment Date/Amt	Period
12/16/2009 ($15.00)	1/1/2007 - 1/19/2010

Statement Date	PLEASE PAY	Due Date
1/19/2010	$22.31	2/8/2010

Account 2-45619.0 | SHOW AMOUNT PAID HERE $

Monthly Statement

Pay To:

THE BORTOLAZZO GROUP LLC PAUL
P.O. BOX 277234
ATLANTA, GA 30384-7234

ADAM L. RUSSELL
2707 COUNTY LINE RD NW
ACWORTH, GA 30101

Please detach and return the top portion with your payment. Retain the bottom portion for your records.

Date	Name	Code	Description	Provider	Fee	Balance
10/18/2009	ADAM	99284	ED E&M LEVEL 4	AMAYA, SHAI	$439.00	
10/18/2009	ADAM	99053	AFTER HOURS FEE IN 24 HR	AMAYA, SHAI	$75.00	
11/02/2009	ADAM	10	PAY UHC 11/2/09	AMAYA, SHAI	($335.84)	
11/02/2009	ADAM	50	WO UCR	AMAYA, SHAI	($140.85)	
11/02/2009	ADAM	COINS	CO-INSURANCE $37.31	AMAYA, SHAI		
12/16/2009	ADAM	2	PAY CHECK 12/22/09	AMAYA, SHAI	($15.00)	
				PATIENT RESPONSIBILITY--->		$22.31

RESP.	Current	31 - 60	61 - 90	Over 90	Balance
Patient	0.00	0.00	22.31	0.00	22.31
Insurance	0.00	0.00	0.00	0.00	0.00
Total	0.00	0.00	22.31	0.00	22.31

Account Balance: $22.31
Patient Due: $22.31

PLEASE PAY ----> $22.31

This is your Emergency Room Physician's Bill and payment in full is due upon receipt. This balance is YOUR RESPONSIBILITY. Please note change of address on the back of this statement. If we do not have your insurance information please attach a copy of the front and back of your insurance card. Thank you for choosing Wellstar Paulding Hospital.

Account: 2-45619.0 *THE BORTOLAZZO GROUP LLC PAUL (706) 310-0381*

WELLSTAR

WELLSTAR PAULDING HOSPITAL S
PO BOX 406166
ATLANTA GA 30384

FC = 82

WEL11T.A397BJ000065.J048F9.000473 000237

ADAM LEE RUSSELL
2707 COUNTY LINE RD NW
ACWORTH GA 30101-6921

Account Summary

Patient Name	ADAM LEE RUSSELL
Account Number	L0929100719
Bill Date	01/10/2010
Type of Service	Emergency Room
Service Dates	10/18/2009
Total Charges	$1,385.00
Patient Payments	-$48.90
Insurance Payments/Adjustments	-$1,291.10
Amount Now Due	**$45.00**

Insurance Information	Policy Number
Insurance 1 - UHC /SHBP PPO OPTIONS	XXXXX3987
Insurance 2 - PROFEE UHC/SHBP PPO	XXXXX3987

If your insurance information is incorrect or if you have insurance that is not listed, please contact WellStar Customer Service at 1-888-442-8162 as soon as possible. Changes to this information may affect how your insurance company pays your claim and may affect the amount due from you.

Important Message

Thank you for utilizing the WellStar Health System as your healthcare provider. It is our mission to create and deliver high quality hospital, physician and other healthcare related services that improve the health and well-being of the individuals and communities we serve.

You have been sent three billing statements and your account still remains unpaid and over due. The balance due is now seriously past due.

There are still other payment options available to you, but you must act immediately to take advantage of them. If payment arrangements or full payment is not made in the next 20 days, your account may be turned over to a collection agency or law office in order to seek resolution.

A summary of your charges and information about paying your bill is found on the reverse side of this statement. If you need a detailed list of your charges, please call WellStar Customer Service at 1-888-442-8162.

Contact Us

Billing related questions?
Contact Customer Service at 1-888-442-8162
Office Hours are 8:00 am - 4:30 pm, Monday - Friday

Online Billing Manager, 24 hours per day, 7 days per week. www.wellstar.org. A simple and easy way to access your updated account information and pay your accounts online.

WELLSTAR

- ✓ Make Check Payable to WellStar Health System.
- ✓ Please include your Phone No. on your check.
- ✓ Enclose this payment stub with your payment

Amount Paid
$

GUARANTOR NAME	ACCOUNT NUMBER	AMOUNT DUE
ADAM LEE RUSSELL	L0929100719	$45.00

Complete the reverse side of this form only if your address has changed.

WELLSTAR PAULDING HOSPITAL
PO BOX 406166
ATLANTA GA 30384-6166

METHOD OF PAYMENT

Check One
☐ Payment Enclosed ☐ Charge (Complete below)

☐ VISA ☐ MasterCard ☐ American Express ☐ DISCOVER

Credit Card Number

Credit Card Expiration Date — 3 Digit Security Code (on back)

Credit Card Holder's Signature — (Cannot be processed without Signature)